TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 0 1

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: February 1. 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 03 $ 4,073
b. FFY 04 $ 6,100

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, page 12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, page 12 (94-38)

10. SUBJECT OF AMENDMENT:
Licensed ICF/MR facilities that are certified to participate in the Medicaid program that are not operated by the State shall pay a monthly assessment fee to the Department.

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Sally Titus Cunningham

13. TYPED NAME:
Sally Titus Cunningham

14. TITLE:
Interim Director

15. DATE SUBMITTED:
January 23, 2003

16. RETURN TO:
Director
Department of Human Services
Hoover State Office Building
Des Moines, Iowa 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
01/27/03

18. DATE APPROVED:
APR 25 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
FEB - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Barbara Smith

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:
SPA CONTROL
Date Submitted: 01/23/03
Date Received: 01/27/03

Instructions on Back

- A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure which increase costs. (Documentation and verification will be required).
- A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Reimbursement Rate (Payment Rate)

The budgeted reimbursement rate is the lower of the maximum allowable cost ceiling or the actual allowable per diem rate.

After the first six months of operation, the reimbursement rate is the lower of the maximum allowable cost ceiling or the actual allowable per diem rate.

The reimbursement rate for all subsequent cost reports is the lower of the maximum allowable cost ceiling, the actual allowable per diem rate, or the maximum allowable base rate.

h. Assessment Fee

Effective February 1, 2003, assessment fees paid by licensed intermediate care facilities for the mentally retarded (ICF/MR) that are not operated by the State will be recognized as an allowable cost.

For the purpose of immediately recognizing the cost of the assessment fee, rates shall be recalculated effective February 1, 2003, to reimburse facilities for Medicaid's share of the assessment.

To determine rates paid for services rendered after February 1, 2003, each facility's annual costs reported for periods before February 1, 2003, will be increased as necessary to reflect an amount equal to the annual cost of the assessment fees. These revised costs will then be used to recalculate the allowable payment rate as specified in Section C.2.g. of this plan. This adjustment to reported cost will continue until the providers' cost reports as submitted reflect the full annual cost of the assessment fees.